Child's Name: _____ Parent/Guardian: _____

Date of Birth: _____ Relationship to the Child: _____

Reason for today's visit: _____New childhood check up _____ Sick Visit (New child)

Allergies: Drugs: _____Foods: _____ None: _____

Family Health History: (INCLUDING CHILD**) O = Negative; X = Positive; U = Unknown**.

	Child	Mother	Father	Mother's Parents	Father's Parents	Siblings
Hypertension/Stroke						
Heart Disease/Rheumatic Fever						
Diabetes						
Cancer						
Sickle Sell/Trait/RH						
Asthma/Allergies/Hay Fever						
Lung Disease/TB/Bronchitis						
Seizures						
Anxiety/Depression						
Alcohol Abuse						
Drug Abuse						
Family violence						
Neuro/Mental Emotional health						
Mental Retardation						
SIDS						
Lead Exposure						
Birth Defects: Congenital/Genetic						
Hepatitis _____ type _____						
Kidney/Urinary Disease/Frequent Urination						
G.I. Problems						
Skin Diseases						
Thyroid/Endocrine						
Other						
Other						

Birth History: _____Unknown by person accompanying child (**11 and older do not complete this section)**

Mother's Prenatal History:

____Hypertension ____RH Drugs: Alcohol Amt. _____ OTC drugs: _____
____ Diabetes ____ X-ray Tobacco Amt. _____
____ STD (Specify) _____ ____ Hepatitis Prescription: _____ Street Drugs_____
____ Rubella (German measles) ____ HIV _____

Prenatal Care Began: _____1st Trimester _____2nd Trimester _____3rd Trimester
Pregnancy History: Pregnant _____times; Delivered _____times; Miscarriages _____; Abortions _____
Delivery History: _____weeks gestation; ____ birth weight: _____birth length
_____ vaginal delivery; ____ Caesarean: _____ Adoption
Name of Facility: _____; Midwife/Physician: _____(name)
Was this child premature: _____yes _____no

Child's History (Please complete the section below for all ages)
Current Medications:
_____

Any serious illness, accidents, hospitalizations, surgeries – (Please list and include dates and outcomes): _____

_____

Frequent episodes of minor illness – (Please list and include dates and outcomes):_____

Blood products Received: Type _____ Date_____ Outcome _____